

Health History Record - Adult

Information:

Name: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Person to contact in case of emergency:

Name: _____ Relationship: _____

Phone:(H)(_____) (B)(_____) Pager/Cellular(_____) _____

Name: _____ Relationship: _____

Phone:(H)(_____) (B)(_____) Pager/Cellular(_____) _____

Physician: _____ Phone: (_____) _____

Medical/Hospital Insurance Carrier: _____ Policy/Group Number: _____

Health History

_____ Tuberculin test (results): _____

Chronic/Recurring Conditions: Check all that apply

- | | | | | |
|--|---|--|---------------------------------------|--|
| <input type="checkbox"/> Asthma/Respiratory Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Bleeding/Clotting Disorders | <input type="checkbox"/> Fainting | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nosebleed | <input type="checkbox"/> Ear Infection |
| <input type="checkbox"/> Special Dietary Regimen | <input type="checkbox"/> Seizures | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Emotional Disturbances | <input type="checkbox"/> Sickle Cell Trait or Disease | <input type="checkbox"/> Musculoskeletal Disorders | | |
| <input type="checkbox"/> Other: _____ | | | | |

Date (mo/yr) last examination: _____ Are activities restricted? Yes No If Yes, explain: _____

Allergies: Check all that apply

- | | |
|---|---|
| <input type="checkbox"/> Food: _____ | <input type="checkbox"/> Plants: _____ |
| <input type="checkbox"/> Insect bites/stings: _____ | <input type="checkbox"/> Medicines/Drugs: _____ |
| <input type="checkbox"/> Hayfever: _____ | <input type="checkbox"/> Animals: _____ |
| <input type="checkbox"/> Pollen: _____ | <input type="checkbox"/> Other: _____ |

Current medication: Specify _____ Is in possession? Yes No

Check if you wear: Contact lenses Glasses Dental appliance Other _____

READ and SIGN: This health history is complete and accurate. I am able to engage in all activities except as noted.

Signature _____ **Date** _____